STUDY OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND QUESTIONING COMMUNITY MEMBERS' PERCEPTIONS OF THE AUSTIN/TRAVIS COUNTY HEALTH AND HUMAN SERVICES DEPARTMENT

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Abstract

In order to measure the cultural competence of the Austin/Travis County Health and Human Services Department (A/TCHHSD) with regards to lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) community members, a brief qualitative study was conducted to measure community members' perceptions of the department. This study, while not exhaustive, does point to some ways A/TCHHSD can improve its relationship with LGBTQ community members. This report explores the ways in which the department can improve the relationship with the LGBTQ community through activities which include becoming a stronger ally, garnering equality in treatment, overcoming negative perceptions, and solidifying the brand that is A/TCHHSD. Increasing cultural competence may happen on multiple fronts, including targeting relevant and sensitive services to the wider LGBTQ community while at the same time making sure staff in all areas is prepared to handle any clients who may also be LGBTQ.

Background

In the course of implementing the Community Transformation Grant to reach underserved populations in the areas of tobacco-free living; active living and healthy eating; high impact evidence-based clinical and other preventive services; and healthy and safe physical environments, A/TCHHSD came to the conclusion that not enough was being done to reach the LGBTQ population. This study is the first step in determining how to better serve members of that community by examining current perceptions of A/TCHHSD and ways in which to increase cultural competency of the outreach components of the department.

As Wujcik notes, "Cultural competence requires having a defined set of values, principles, behaviors, attitudes, policies, and structures that enable people and organizations to work effectively cross culturally. It also requires the capacity to value diversity, conduct a self-assessment, manage dynamics of difference, and adapt ... Cultural competence is being respectful of differences between people, accepting and valuing differences, self-monitoring, and taking responsibility for thoughts, behavior, and outcomes" (2011:5). This study takes as its starting point the idea that cultural competency with respect to LGBTQ community members, can be increased through dialogue resulting in concrete recommendations for an improved relationship between LGBTQ individuals and A/TCHHSD.

Terminology

It is difficult to speak of the LGBTQ community as a single population. Each subgroup is distinct from the others and may only be lumped together in their location as non-heteronormative. As Kitzinger explains, "The term 'heteronormativity' is widely used in

contemporary political, social, and critical theory to describe socio-legal, cultural, organizational, and interpersonal practices that derive from and reinforce a set of taken-for-granted presumptions relating to sex and gender. These include the presumption that there are only two sexes; that it is 'normal' or 'natural' for people of different sexes to be attracted to one another; that these attractions may be publicly displayed and celebrated; that social institutions such as marriage and the family are appropriately organized around different-sex pairings; that same-sex couples are (if not 'deviant') a 'variation on' or an 'alternative to' the heterosexual couple. Heteronormativity refers, in sum, to the myriad ways in which heterosexuality is produced as a natural, unproblematic, taken-for-granted, ordinary phenomenon" (2005:478). Heteronormativity frames most discussion, whether explicitly or implicitly, making it easy to miss the fact that members of the LGBTQ community have different experiences than people who have mainstream gender presentations or a heterosexual orientation.

In the interest of clear communication, I offer definitions of the terminology used in this paper following the UC Berkley Gender Equity Resource Center (2012).

- Lesbian – A woman attracted to a woman.
- Gay – A man attracted to a man.
- Bisexual – A person who is attracted to two sexes or two genders, but not necessarily simultaneously or equally. Historically, this has been defined as a person who is attracted to both genders or both sexes, but recent debate has called this definition into question because more than two genders or sexes are now recognized in the community. It is used here as part of the traditional nomenclature, but not without reservation.
- Genderqueer - A person who redefines or plays with gender, or who refuses gender altogether. This is used as a label for people who bend/break the rules of gender and blur the boundaries.
- Transgender - A person whose psychological self (gender identity) differs from the social expectations for the physical sex with which they were born. Transgender is not a sexual orientation; transgender people may have any sexual orientation.
- Queer – An umbrella term to refer to all LGBTQ people. A political statement, as well as a sexual orientation, queer advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid. Some older community members are reluctant to embrace this term because it has been used as a term of derision.
- Questioning – A person who is exploring their sexual orientation or gender and therefore may not identify with any definite category.

As inclusive as the above categories may appear, it is a mistake to think they capture all the possible variations of sexual orientation or gender. United by political expediency and their opposition to heteronormativity, these groups broadly point to a population with special needs that are sometimes overlooked in a healthcare context. Interviews in this study did not include

people in each of these specific categories, but we use the term LGBTQ to connect this study to the larger body of literature on this subject.

Barriers to Care

The issues experienced by LGBTQ community members in healthcare have only recently begun being studied systematically in mainstream journals, disciplines, and media (Bradford et al. 2012a; Bradford et al. 2012b; Cochran, Peavy, and Cauce 2007; Felt et al. 2011; US Department of Health and Human Services 2011). One of the strong possibilities for creating more reliable data on this topic comes from the push toward electronic medical records, which makes it easier for providers to collect data and correlate outcomes based on sexual orientation and gender identity (Bradford et al. 2012a). Of course, qualitative studies offer valuable insight into what statistics mean (cf Bjorkman 2009, Willging 2006), fleshing out numbers with actionable anecdotes.

Heteronormativity, especially experienced as heterosexism (the belief that heterosexual relationships are the only appropriate ones) or homophobia (the irrational fear and intolerance of people who are not heterosexual), has direct consequences on how LGBTQ people access healthcare, including delaying care or dropping out of treatment (Cochran, Peavy, and Cauce 2007) or not disclosing important aspects of their lives due to fear of discrimination (Felt et al. 2011). On the other hand, providers who are LGBTQ friendly have better success discussing risks (Klitzman and Greenberg 2002). Increasing cultural competence creates a safe space for LGBTQ community members to disclose their identities, increasing the chance for the provider to reach them with appropriate materials and services. Although much of this work addresses a clinical setting, it is easy to see how the lessons learned there may be applied to an education/outreach setting.

Health Disparities

Members of the LGBTQ community have higher risk factors than their heterosexual counterparts in some cases. Lesbians and bisexual women, for example, may have a higher risk of breast cancer, depression, or heart disease (Gay and Lesbian Medical Association 2006). Some of these risks are based on socio-cultural patterns, such as a higher prevalence for tobacco usage, stress caused by stigma, or physical inactivity (Gay and Lesbian Medical Association 2006). The fact that these risks may be mitigated through social factors makes education and outreach particularly important. Gay and bisexual men have slightly different risks, such as increased risk for anal cancer, body image problems or eating disorders, and sexually transmitted infections (Gay and Lesbian Medical Association 2006). Again, some of the heightened risk stems from socio-cultural patterns. Bisexual people have higher rates of depression and tobacco usage than their lesbian, gay, and heterosexual counterparts (Substance Abuse and Mental Health Services Administration 2012). Transgender people face many of the same risks as lesbians, gay men, or bisexual people, but also have a much higher risk of physical violence or sexual assault and, in some cases, face more intense stigma (Substance Abuse and Mental Health Services

Administration 2012). Limited data on the experiences of transgender individuals impedes a full comparison of health risks to gender conforming people. In addition to specific risks, many LGBTQ people lack health insurance, making confronting these risks even more difficult.

Sexual orientation and gender identity are not the only qualities that complicate the healthcare picture for LGBTQ people. In a study such as this, it is tempting to focus on those factors, but it is important to take into consideration other barriers to care, such as ethnicity (David and Knight 2008; Hwahng and Lin 2009), age (David and Knight 2008), physical ability (Kelly and Robinson 2011), cultural factors (Hwahng and Lin 2009; Jarama et al. 2005; Nakamura and Zea 2010), and socio-economic status (Grant, Mottet, and Tanis 2011). When reaching out to the LGBTQ community, one should avoid totalizing narratives that ignore other vectors of oppression.

Methods

This brief study pulled a convenience sample from existing social networks to examine general knowledge and perceptions about A/TCHHSD. Beginning from a list provided by A/TCHHSD of people interested in a LGBTQ Taskforce, we began contacting people. In the end, it was easier to locate people willing to participate from the entertainment community and the recovery community. Eight interviews were conducted with people from different walks of life. We controlled for gender, ethnicity, and income. Four women, three men, and one genderqueer person were interviewed. Regarding ethnicity, four white people, three Latino/Latina people (including on black Latina), and one Asian-American person participated. It is a shortcoming of this sample that the one person who identified as black did saw herself as Caribbean rather than African-American, therefore this group is unrepresented; however the small sample size and short time frame presented challenges with recruiting. Income varied from $5,000 per year to $70,000 per year, but skewed to the lower end of the spectrum. Another problematic category is age. The entire sample falls between the ages of twenty-four and forty. People under the age of eighteen were excluded due to logistical issues with consent, although this may be the sector with some of the greatest needs for service. Despite efforts to locate elders in the LGBTQ community, none were found in the time allotted. Additionally, everyone interviewed was able-bodied. LGBTQ individuals with disabilities may have needs that are outside of the scope of this project. Future work should address a greater range of ages, ethnicities, and levels of physical ability.

In addition to the eight interviews, Dr. Luminais performed two brief stints of participant-observation. On September 22, 2012, she attended Austin Pride to observe what kinds of outreach were occurring and which seemed to be attracting the most people. On September 24, 2012, she visited the STD Clinic at the RBJ Clinic. She spoke with the head nurse about the intake process and examined the literature available at the clinic. Additionally, she spoke with one of the people who works with the mobile outreach van.

Dr. Luminais interviewed each participant in person using semi-structured interviewing techniques. Participants signed informed consent forms to be apprised of their rights as participants. Consent forms are attached as Appendix A. The interview schedule is attached as Appendix B. Interviews were recorded and transcribed immediately afterwards. Transcripts were then analyzed using AtlasTI qualitative data software. Employing grounded theory analysis, we identified recurring themes that form the basis of the results reported below. Themes were explored for coherence and correlation.

Results

In order to reflect the wide variety of experience of the LGBTQ community, people from different walks of life were interviewed. According to H. Russell Bernard and Gery W. Ryan (1998), analysis of text and discourse utilizing grounded theory allows for researchers to better understand the participant. It "provides rigorous and detailed method for identifying categories and concepts that emerge … and … helps the researcher link the concepts into substantive and formal theories" (Bernard & Ryan, 1998: 608). In total, seven key patterns were extracted and determined to be relevant to the current study: positive experiences and attitudes regarding A/TCHHSD; a feeling that A/TCHHSD should be an ally to the LGBTQ community; a desire for equal treatment regardless of gender or sexuality; concerns regarding allocation of resources; negative perceptions of A/TCHHSD, particularly in reference to the treatment of personal information; confusion of A/TCHHSD with other City of Austin and Travis County brands; and, possible symbolic gestures that may help create a more welcoming relationship between the LGBTQ community and A/TCHHSD. Each of these themes is outlined in more detail below.

Positive Experiences

Of the five people who had direct experience with A/TCHHSD, all reported positive interactions. For the gay men in this study, this experience was based on involvement with the STD Clinic, which was the most recognized service offered by A/TCHHSD. Jason[1], a gay man in his twenties, worked in a non-profit organization that teamed with A/TCHHSD for HIV screening. He stated, "I found them to be very helpful. I found them to be, as if we were all on the same team, working together for a common goal. I was very impressed with their professionalism." Kelly, also a gay man in his twenties, frequently gets tested at the STD clinic. His comments were that the clinic is "super-efficient. Because when you go in and get tested, they give you the results right then. Well, 20-30 minutes later. You can get HIV results on the spot, which is incredible. And it's nice to just have that out of the way."

A/TCHHSD also tests on-location through the Prevention Counseling and Partner Education program. One man explained, "Someone I was with tested positive for something ... and gave them the wrong phone number for me. After trying to get a hold of me at the wrong number, they sent somebody out to do on-the-spot testing, which I didn't know about. They

[1] All names have been changed.

found my address, which is a little big brother and kind of terrifying, but at the same time I was very happy because that was something I definitely wanted to know about. I don't know what you would call that – travelling service, I guess. The woman who came and tested was absolutely incredible. Just dealing with her made the entire stressful situation less so." The thoroughness of the clinic in locating impacted individuals is seen as a positive aspect.

Because of the STD Clinic's longstanding relationship with the community, and gay men especially, even people who did not use the clinic recognize its importance in the community. The women interviewed did not seem particularly worried about their own exposure to STDs, which may be a function of the fact they were all in long-term, partnered relationships. The genderqueer person was aware of the clinic and had friends who were tested there. They[2] were concerned with STDs that could be transmitted to non-male-bodied people. They said, "The things that people consider to be more 'minor' STDs are also really worrying to me, because who wants the clap? Nobody wants the clap. But who thinks about it? Not anybody. I think that is also a perception shift that needs to happen within my own cohort. It's sort of two-sided." Two of the men noted that they received full STD screenings, including the dreaded "Q-tip test" (a sample taken by swabbing the urethra), while the third only got tested for HIV.

The work being done by the STD clinic is valuable. In one case, a person who was not knowledgeable about the clinic offered this advice to young gay men, "We tell them to give blood. Tell them to donate blood and they'll find out [if they have HIV]. Because that's all we know to tell them." This person was unaware that the fee for STD testing, including HIV, can be waived at the clinic for those in need. This person was part of a community focused on recovery from addiction. This may be an area of outreach A/TCHHSD should explore in the future.

Positive experiences were not limited to the STD clinic. Two of the lesbian women interviewed were involved with Refugee Services immediately after their arrival from Cuba six years ago. Their experiences were generally good, although one of them objected to the required Pap smear, noting, "I felt uncomfortable with the vagina test, that was, like, rude. The size and the attitude. They say you have to do that frequently, but you... sometimes... I don't know, to be more delicate or more gentle." As a lesbian, she believes her sexual health is safeguarded because she does not have sex with men. The misgivings here are an illustration of how sexual orientation and ethnicity intersect. That being said, these women felt they were treated well and that being queer[3] did not mean they were treated differently.

Finally, some people have a feeling of diffuse goodwill about Austin as a city which carries over to how A/TCHHSD is perceived. Grace said, "I think Austin has largely a reputation of being welcoming to diverse people, you know, Keep Austin Weird thing. Pretty

[2] This person prefers the pronouns "they/them." Respecting their wishes, we use the same convention. Efforts have been made to ensure it is obvious when the singular "they" is being used.
[3] Whenever possible, we use the self-identified labels people offered for themselves.

open to people of all different kinds. So I think my usual assumption for places in Austin is that they are going to be pretty welcoming." Furthermore, Grace had specific concepts about the types of people who work for the City of Austin, noting, "I think if you are working for City government, or working for County government, you have like a set of rules that you follow. I think that by the nature of that sort of occupation here in Austin, that person is different and more thoughtful than the general public." This goodwill can easily be disturbed by personal reports of negative experiences, so should not be relied upon to shape all of people's experiences. Below, we discuss the opposite of this attitude – a suspicion of all governmental entities.

The City of Austin has, at the time of writing, made some significant gestures supporting the LGBTQ community, including the Austin Police's Departments "It Gets Better" campaign (Lesbian and Gay Police Officers Association 2012) and the City Council's 2012 resolution declaring the City of Austin's support of marriage equality in Texas (Resolution No. 20120927-077).

There are many reasons some members of the LGBTQ community feel good about A/TCHHSD, including relevant services offered in an efficient and professional manner. For many people, not being treated differently because of sexual orientation or gender expression goes a long way. Strengthening these aspects of A/TCHHSD can only add to a welcoming environment for LGBTQ community members. Furthermore, A/TCHHSD can capitalize on the goodwill generated by recent outreach on the part of the City of Austin.

Allies with the Community

People in the LGBTQ community want A/TCHHSD to be true allies, stressing the relationship as a partnership rather than a faddish project. It will take time to demonstrate the sincerity of A/TCHHSD's commitment to inclusivity. Inclusion, sponsorship, and endorsements are concrete ways of interacting with the community.

One of the important distinctions people interviewed made was between "diversity" and "inclusiveness." There is the feeling that the rhetoric about diversity limits itself to including people from different ethnicities or even cultures, but does not address other areas of difference, including sexual orientation or gender identity. As Grace stated, "Everyone wants to feel included, no matter who you are." A/TCHHSD would benefit from framing discourse as inclusivity.

Being inclusive not only makes LGBTQ people feel more welcome and more likely to access services, but also directly benefits the organization. In a study about the impact of inclusiveness on sports organizations, Cunningham and Melton note, "Sexual orientation diversity is posited to positively contribute to organizational effectiveness through three mechanisms: enhanced decision making capabilities, improved marketplace understanding, and

goodwill associated with engaging in socially responsible practices" (2011:647). Here, we present actionable items to increase inclusivity and cultural competence. Creating respect through direct engagement with the community underlies each of these recommendations.

Repeatedly, people mentioned sponsorship as an important indicator of commitment. At Austin Pride, A/TCHHSD had a presence in front of the festival in the form of the mobile health van offering free STD testing. There may be some dissonance between what A/TCHHSD understands is its projected image and how it is viewed by the community. Speaking with one of the public health program specialists, he expressed that A/TCHHSD did not pay for a booth because it would be people's tax dollars being spent when that money could go to more testing. However, some City of Austin departments, such as the Austin Police Department and 311 had a presence inside the festival, so I think the community may be receiving mixed signals about A/TCHHSD's position. Sponsorship is about more than just booth space; it is also taken as a measurement of commitment. Grace suggested, "Be a participant in the Queer Pride Parade or Festival. I know that Dell as a company is very welcoming to gay people because they are in the Pride Parade. They're out there and have their logo all over stuff. They have gay people marching in the parade."

Active participation matters. Note that Grace specifies that they have gay people marching in the parade. Jo also focuses on the inclusion of LGBTQ members in outreach efforts. I quote them at length for their explanation of why this is important:

> It would be really easy to just send a couple of muggles [people outside of one's social circle and unaware of its activities] in the van to those things but I would highly discourage that because it would just be wasting everyone's time. There's a function of like, if I see a health services situation going on in a van or whatever, I'll be less inclined if zero of those people (and I know this is a fucked concept) look queer. If they aren't reading me or I'm not reading them, I'm much less likely to walk up, because I'm like, super, someone who's not going to get me. No thanks; I can get that in network on my own time, not at QueerBomb or Pride. I can use this time to have a beer instead. It's not super personal. Some people doing outreach are so square! I know that they're earnest and they are probably the sweetest goddamn people in the world; I'm sure that they are super tender, but this is the same reason I wouldn't send my sister. For all that she gets it and all that she's on it, she looks like a sorority girl because she is one. I'm not going to send her out to do queer outreach for whatever the hell she's doing, because she looks like a square. Nobody's going to walk up to her. Well, that's a lie, there will be some people who would walk up to her, but it will not be as variegated or as wide an audience as she could reach. It's not that they don't look sweet; it's just that so frequently there are a lot of really sweet people who are completely oblivious. It's not that they are intending to say things that are off or behave in ways that indicate they have no idea what

the hell is going on, but that ends up happening. People sometimes think they are being radical, but they are being liberal, which is different.

Lacking LGBTQ employees who want to participate in outreach efforts, some community members are open to the possibility to volunteering.

Endorsements from people in the LGBTQ community are cited as a vital influence. Repeatedly, respondents stressed the importance of word-of-mouth in their evaluations of services. Of course, all people should be treated with respect and compassion, but when reaching out to an underserved population, it is important to keep in mind that each encounter informs a dense network of individuals. One of the strategies suggested by a respondent was to recruit a spokesperson for A/TCHHSD from the LGBTQ community. At one point, Grace specifically noted that if a well-known drag queen said, "'Those folks from the City, they'll treat you right' or whatever, that would make a pretty powerful marketing campaign amongst the queer community." I recommend exploring the option of enlisting the help of entertainers in the LGBTQ community to spread the message about services. Other entertainer groups include the local drag king troupe or the queer hip-hop scene.

Commercial endorsements are also valid, such as the Gay Yellow Pages, the Austin Chronicle – Gay Place, or L Style/G Style ("a luxury lifestyle magazine that profiles gay and lesbian leaders and their straight allies"). LGBTQ groups sometimes endorse entities. Examples of endorsing groups are the Human Rights Campaign or the Gay and Lesbian Alliance Against Defamation. However, the best known service, the STD Clinic, cannot handle more clients without an increase in staff. Endorsements should focus on those areas that A/TCHHSD wants to promote, such as nutrition classes or tobacco cessation, or A/TCHHSD as a whole.

Equal Treatment

At first blush, this may seem obvious. People want to be treated equally, irrespective of sexual orientation or gender expression, but across the board, this was important. When speaking positively about the STD Clinic, Jo noted, "It's not necessarily friendly nor hostile, which is sometimes really a nice thing to have happen for queer folks, especially visually queer folks, that they neither get harassed nor particularly welcomed, it doesn't seem like they are getting treated differently than anyone else who goes in there." Also describing his experiences at the STD Clinic, Kelly says, "I mean, aside from the basic stress of going to get an STD test, they are fine. It's very clinical, but they're not gruff or rude, which they very well could be." Grace stated, "If I need help, I hope they treat me just like any other person instead of queer or Asian." When speaking about her vision for the future, Ana said, "I hope one day there will be educational programs to teach how to be different or how it's possible to be different, how it's not only like men and women. About lesbians, gays, straights, bisexual, transgender, all of us, we are part of this society, part of this world. We are the same animal – human beings – the same kind." When working with the LGBTQ community, it is important to remember that a

person's sexual orientation or gender identity is not the sum total of who they are. As Kelly noted, "My sexuality is tertiary to my personality."

Allocation of Resources

In some cases, people believe the allocation of resources is proportionate to the need in the community, while in others, the concerns of participants do not align with A/TCHHSD's programs. With one exception, people believe that testing services for HIV are easily available and low-cost or free. This met the expectation that concerns about HIV transmission are taken seriously. However, some people raised the question about the resources available to a person once a positive test result is returned. Due to the limitations of this project, this line of inquiry was not pursued, but offers a future direction for research.

Individuals evinced interest in some of the programs offered by A/TCHHSD that they were previously unaware of, such as Diabetes Prevention and Intervention or Permanent Supportive Housing. People also expressed a desire for more cancer screenings. Addiction was one subject that came up repeatedly, especially to methamphetamines. Jo acknowledged that A/TCHHSD has made some strides in its tobacco-free living campaign, but "I'm super curious about outreach besides tobacco cessation. Addiction rates for everything, ever, are a gazillion times higher in queer communities than anywhere else. I totally understand that they may want to get their feet under them with regards to other service provision first, but eventually branching out to all sorts of addictions." When asked about what pressing concerns he felt the LGBTQ community was facing, Jason said, "Meth use in the community is so rampant. That is what progresses the HIV epidemic. Because meth and sex go hand in hand, they [meth users] are having sex with all of these guys and some of these guys don't even know that they are HIV positive." Addiction is tied to other risky behaviors, increasing the LGBTQ's vulnerability to certain healthcare issues.

One unexpected result of this study was the belief some people held that they did not need the services provided by A/TCHHSD. This is particularly noteworthy because many people in this study earned less than $25,000/year or, in two cases, were unemployed. In some instances, people did not see A/TCHHSD as a resource because they had health insurance, either through their employer, as a musician, or through Medicare. In other cases, people felt their general health was good. Both of these evaluations rely on the cultural model of a health department being a reactive entity rather than a proactive one.

People do not associate preventative strategies with A/TCHHSD. Grace explained, "It's because you don't think of health and human services as a fun thing, that's where you go if you have an issue or a problem that you are trying to solve. I guess there's preventative stuff, which is different. I mean, you're not really trying to solve a critical problem or issue, you're just looking to not have a problem." Reshaping the ideology of public health to encompass preventative measures in the public imagination may be beyond the ability of A/TCHHSD, but it

is noteworthy for future research and outreach endeavors. Interestingly, people supported the existence of programs, even when they did not feel the particular need for them themselves, including the African-American Quality of Life initiative and the Day Laborer program.

Negative Perceptions

Not everyone reported positive feelings toward A/TCHHSD, although no one had a direct negative interaction with the department. There exists a deep suspicion of state agencies in some sectors of the LGBTQ community, especially with regards to the police. Jo, the genderqueer person, said, "The issue is that a lot of people in my community, myself included, are not cop-friendly and a lot of us have this perception that any state agency or anything affiliated with the state is going to be cued in with the cops, right? Which can be really nerve wracking, even for those of us who don't engage in particularly illicit things. There's an overwhelming sense that the cops are not there to protect us. They are there to protect me, more so than, say, other folks in my community. They are more willing to not be dicks to me. And also I recognize that they are very willing to be dicks to some of my friends because of their issues and systemic blah blah blah... So, maybe being really clear about whether/or not things will be divulged to authorities." Jo reminds us that sexual orientation and gender expression are not the only areas of identity that might create tension between healthcare personnel and members of the LGBTQ community. Their recommendation to clarify how the information collected will be used may be more applicable to clinical settings that measure risk behavior, but the sentiment may also apply if outreach is performed in community settings such as bars or the bathhouse.

Grace also expressed ambivalence about how police interactions relate to other social services when she said, "There was something that happened a few years ago that I heard about – a gay man got beaten up by Fourth Street and the cops didn't do anything. I think that there were two stories like that that were spread around the gay community. When I heard that it made me really angry and made me wonder if public services cared at all. But that was a few years ago. Maybe some things have been done to resolve issues like that." This demonstrates how easily one or two negative incidents can color a person's perception of all public service jobs. The weekend of Austin Pride, two men were attacked downtown in a possible "bias crime" (Sandoval 2012). The LGBTQ community is keeping a close eye on how the police respond to this incident. It remains to be seen how the community will judge this interaction.

Brand Confusion

People were surprised that A/TCHHSD offered so many services. Even if respondents were familiar with some of the programs, they often had no idea that it was A/TCHHSD offering these services. When relying on word of mouth for recommendations, lack of branding and atomized services limit the usefulness of community endorsements outside of specific programs. Goodwill generated by a positive experience at the STD Clinic will not carry over to preventative outreach efforts, such as nutritional classes, if people do not know the programs are related. At the STD Clinic, however, clients are asked about whether they use tobacco, and if so,

the staff offers them literature created by A/TCHHSD through the Communities Putting Prevention to Work program on tobacco cessation. This is a positive example of connecting services to one another.

On the other hand, many people conflated A/TCHHSD with the City of Austin as an entity, making no distinction between the health department and other city services, such as cultural arts funding. Grace compared the indistinctness of A/TCHHSD to the active efforts of Austin Resource Recovery to re-market itself to the public, noting that even though Austin Resource Recovery is "basically people who collect the garbage," she had recently learned about their role in recycling and other programs through an interview on KUT.

In other instances, Austin/Travis County Health and Human Services Department is confused with Austin/Travis County Mental Health and Mental Retardation. People persist in referring to the latter as Austin/Travis County MHMR despite their recent name change to Integral Care. When asked about A/TCHHSD directly (without the acronym), David explained, "I was a service provider for a non-profit organization and I would utilize Austin/Travis County MHMR as a resource and also I worked as an investigator for child protective services for a year and a half and would use them as a resource as well."

Finally, two of the women received healthcare from Seton due to their involvement with the Health Alliance for Austin Musicians. They were not clear about how A/TCHHSD's services differed from Seton's. This confusion is compounded by the fact that the department has partnered with Seton in the past to provide some services.

Symbolic Gestures

There are some simple, concrete steps that outreach programs and clinics can use to make LGBTQ people feel more welcomed. Symbols, such as language and signs, make a deep impact on our personal identity and group affiliations because they are often the first markers people readily recognize. We look for subtle cues in language to tell us if another person is an insider or an outsider so we know whom we can trust (Joseph 2004). Cintron (1997) points out that people affirm their identities through signs and symbols other than language, such as wearing particular brands or driving specific cars. People further count on these signs and symbols as a quick way to determine the legitimacy of others' identities, particularly group identities (Cintron 1997).

To this end, pamphlets, flyers, or wall posters, which picture a variety of families, including same-gendered partners or gender ambiguous people may aid in creating a welcoming, symbolically appropriate atmosphere for A/TCHHSD. Almost everyone interviewed said they immediately notice advertising that includes families that look like their own. Additionally, the inclusion of magazines geared toward the LGBTQ community, such as L Style/G Style, in the reading material in waiting rooms may further garner an attitude of acceptance.

There are several symbols that can be used to further indicate support for LGBTQ community members, including the rainbow flag or the pink triangle. The symbol of the Human Rights Campaign (a yellow equal sign on a blue background) is an endorsement of marriage rights for same-gendered partners, although this is not without political implications. Some queer people feel alienated by the marriage equality movement. Ally symbols, such as the green circle around a pink triangle or actual descriptions of what it means to be an ally, may also be effective. Obviously, these cosmetic changes do not outweigh the treatment people receive, but LGBTQ people notice very quickly whether there are any clues that they will be particularly welcomed.

Many people also cited gender-neutral language as an important indicator of support for the LGBTQ community. When asking about primary relationships, it is better to ask about a partner or a spouse rather than assuming someone has a husband or a wife. Additionally, if a person's gender presentation is non-conforming, it has become acceptable to ask which pronoun that person uses. On questionnaires requiring a person to disclose gender, an option that welcomes transgender people would be "male/female/other."

Conclusions

This study has measured a small sample of LGBTQ community members' perceptions of A/TCHHSD, but deeper organizational assessment would benefit the department. There are assessments in which A/TCHHSD can participate to measure current cultural competence. The best known is the Healthcare Equality Index, offered by the Human Rights Campaign, which "surveys and rates respondents on their policies and practices related to lesbian, gay, bisexual and transgender (LGBT) patients and families. The HEI is skillfully designed to allow U.S. healthcare facilities to assess the degree to which they provide LGBT patient-centered care, to identify and remedy any gaps and to make public their commitment to LGBT patients and their families" (Human Rights Campaign 2012).

Training is an important first step in increasing cultural competence. The Gay and Lesbian Medical Association offers a webinar series on LGBTQ cultural competence that would be appropriate for all divisions of A/TCHHSD. The New York State Office of Mental Health has training titled "Introduction to Therapeutic Work with Transgender Clients" (Stone 2012). The beginning of this webinar may be useful to anyone at A/TCHHSD, while the later parts apply to clinic settings specifically. The National Resource for LGBT Aging offers a series of webinars on LGBT issues among older people (National Resource Center on LGBT Aging 2012). University of California San Francisco – LGBT Resource Center (UC San Francisco 2012) offers technical assistance in creating institution specific trainings. Training options can be tailored to individual or group needs, either online or in person.

Intergroup dialogue is a step beyond didactic training. It is a form of social justice education found on some college campuses. It involves bringing together people from two

different groups in order to learn about each other's way of being in the world. Generally, one group is taken from the "target, or oppressed, group" and the other from "the agent, or privileged, group" (Dessel et al, 2011:1134). Interactions are co-facilitated by people who identify with each group. This method lends itself to a long-term engagement, but could be adapted to fit one or two sessions for outreach workers and members of the LGBTQ community. This could serve the dual purpose of increasing cultural competence on the part of A/TCHHSD while at the same time educating LGBTQ community members about A/TCHHSD's goals and programs.

Other suggestions to create a more welcoming atmosphere for LGBTQ people at A/TCHHSD include continuing to offer professional, efficient, thorough services that are relevant to the community; capitalizing on the diffuse goodwill generated by being a part of the City of Austin; actively participating in community events; seeking endorsements from well-known LGBTQ community members and organizations; treating people equally; assessing whether A/TCHHSD's efforts are addressing community needs; reassuring community members that information collected by A/TCHHSD will not be shared with the police; developing a distinct, unified brand; and making concrete, symbolic gestures toward inclusivity, including using gender neutral language and representing LGBTQ people on outreach literature. Although this study was brief, we hope it has offered insight into the LGBTQ community in Austin. A/TCHHSD has much to offer this community. Better communication on both sides can leverage the benefits of this relationship into an even more effective use of resources in a culturally appropriate manner.

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Appendix A – Consent Form

Study of Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Community Members' Perceptions of Austin/Travis County Health & Human Services Department

Researcher: Misty Luminais, Ph.D.
mistyluminais@gmail.com
(509) 263-8705

Researcher's Statement

You are being asked to participate in a research study involving the perceptions of people who identify as lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) about the Austin/Travis County Health and Human Services Department (A/TCHHSD). The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read this form carefully. You may ask any questions you have about the purpose of this project, what I am asking you to do, your rights as a volunteer and anything else you feel is not clear on this form. When I have answered all of your questions, you may decide if you wish to be a part of this study or not. This process is called 'informed consent'. I will give you a copy of this form for your records.

Purpose and Benefit

The purpose of this study is to examine how members of the LGBTQ community perceive A/TCHHSD through their own experiences or through shared community knowledge. The goal of this study is to offer suggestions to A/TCHHSD about how to better welcome members of the LGBTQ community and offer them culturally appropriate services. You will be compensated $25 for your participation.

Procedures

I will ask you a series of questions about your general perceptions of A/TCHHSD, whether you have knowledge or experience with particular programs, and how A/TCHHSD could better serve LGBTQ community members. I will also collect basic demographic data to ensure that the study reflects different social positions. The interview will be recorded and I will take handwritten notes. Members of A/TCHHSD will have access to all the data I collect but if you chose to keep your identity private, I will use a pseudonym in my report. Additionally, Michelle Fiedler, Ph.D., will also be working on data analysis and will have access to the data. With your permission, information from the interview may appear in future publications.

Risk, Stress, or Discomfort

The risks for this interview are relatively low. However, talking about sexual identity and health can sometimes be discomforting. If you feel uncomfortable at any time, please tell me. Your participation is voluntary. You may refuse to answer any question asked and you may ask to end the interview at any time. You may also ask to be removed from this study at any time by calling the number listed below with no penalty or loss of benefit.

Funding
This study is being funded by the Austin/Travis County Health and Human Services Department as a recipient of a Community Transformation Grant from the Center for Disease Control (Grant No. CDFA# 93.531).

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Printed Name of Researcher Signature of Researcher

Contact information of researcher: Misty Luminais
mistyluminais@gmail.com
(509) 263-8705

Contact information for A/TCHHSD: Ashley Pudnos
ashley.pudnos@austintexas.gov
(512) 972-6464

Participant's Statement
This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have general questions about the research, I can ask the researcher listed above. I will receive a copy of this consent form.

_____

Printed Name of Participant Signature of Participant Date

Appendix B – Interview Schedule

Interview Questions for Study of LGBTQ Community Members' Perceptions of A/TCHHSD

How do you identify your sexual orientation/gender?
What groups are you a member of?
What do you think about A/TCHHSD?
Do you know about or have you had experience with any of the following A/TCHHSD programs: (if so, how welcome did you feel as an LGBTQ person?)

- Immunizations
- Refugee Services
- Injury Prevention
- Day Labor Program
- Neighborhood Centers
- HIV Planning Council
- Diabetes Prevention and Intervention
- Tobacco Prevention and Cessation
- Permanent Supportive Housing
- African American Quality of Life
- Tuberculosis Outreach
- STD Clinic
- Other

What clues do you look for that a service is LGBTQ friendly?
How could A/TCHHSD reach your community? (social media, word of mouth, flyers, etc.)
What concerns would you like to see A/TCHHSD address?

Demographics:
How old are you?
What is your ethnicity?
Do you have any physical disabilities?
What is you approximate income?
Do you have insurance?
What is your partner status?
Do you have children?

Do you have any final thoughts on anything we have discussed?